STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

v **File No. 122809-001**

Blue Care Network of Michigan

Respondent

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Issued and entered
this 19th day of December 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On August 10, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Petitioner has been a member of Blue Care Network of Michigan (BCN) since January 1, 2003, under a group plan issued to his employer. His health care benefits are defined in the *BCN 10 Certificate of Coverage* (the certificate) and *BCN's Healthy Living* rider (the rider).

The Commissioner notified BCN of the request for external review and asked for the information it used to make its adverse determination. BCN submitted its initial response on August 12, 2011. After a preliminary review of the material submitted, the Commissioner accepted the request for external review on August 17, 2011. BCBSM provided additional information on August 19, 2011.

The issue in this external review can be decided by an analysis of the terms of the rider. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner was enrolled in BCN's Healthy Living program in 2007. The Healthy Living program is a BCN program designed to promote good health among members willing to participate. Members must meet several requirements, such as an annual physical, and are rewarded with financial advantages such as lower copayments, coinsurance, and/or deductibles.

One requirement of the Healthy Living program is that members must complete an online "health assessment" form annually in order to continue to receive the Healthy Living benefits. BCN removed the Petitioner from the enhanced benefit plan and placed him in the standard benefit level with the higher out-of-pocket expenses when he failed to submit the required health assessment form by the deadline of March 31, 2011.

On April 1, 2011, the Petitioner received emergency medical assistance and required several subsequent follow-up visits to a physician. BCN processed the claims at the standard benefits level.

On May 6, 2011, BCN received Petitioner's health assessment form and reinstated his enrollment in the enhanced benefits level effective May 6. The Petitioner requested that his enrollment in the enhanced benefits level be made effective for the period of April 1 through May 5, 2011. BCN denied the request. The Petitioner appealed the denial through BCN's internal grievance process. BCN maintained its denial and issued its final determination dated July 28, 2011.

III. ISSUE

Did BCN properly deny the Petitioner participation in the enhanced benefit level of coverage for the period of April 1 through May 5, 2011?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination of July 28, 2011, BCN wrote:

> . . . Based upon the information reviewed, your request has been denied because you completed your online Health Assessment (HA) after the due date of March 31, 2011. Your contract will remain in the standard level benefit from April 1, 2011 - May 5, 2011, you will be responsible for any charges applied to the standard level benefits during this time period. Your contract was returned to the enhanced level benefit on May 6, 2011.

Petitioner's Argument

In a letter accompanying his request for external review, Petitioner wrote:

> [T]he requirement to complete a web survey to qualify for enhanced benefits is nothing more than a tactic by BCN to reduce its financial exposure for the benefit payments to its members. Proof of that is simple, as any member can provide inaccurate answers to the web survey questions to qualify for enhanced benefits, and as long as those inaccurate answers are provided to BCN by the unilaterally imposed deadlines, enhanced benefits will remain in place. Obviously, the requirement of BCN to also conduct an annual physical by the unilaterally imposed deadline is a means of validating the redundant information that would have otherwise been provided through a web survey.
>
> So, if members can provide any answer they see fit through the web survey, BCN must rely entirely on the annual physical results to validate these answers. Therefore, and logically, as an unreliable source of member information, the web survey is not important medically, it is only important as a means of disqualification. . . . In my case, I did complete the annual physical within the unilaterally imposed BCN deadline, and because I did not complete a meaningless web survey by a unilaterally imposed BCN deadline, my coverage was reduced. Does BCN care more about me being healthy or does it care more about me completing a web survey by a unilaterally imposed deadline? BCN's conduct in this regard demonstrates that completion of a web survey is far more important. Rest assured, I am healthy (see my physical), yet for the days between April 1st and May 6th, I was not considered healthy in the eyes of BCN, due to the fact I did not complete a web survey.
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> You should also note that a critical point in this whole matter is the fact that BCN provided me notification of my reduced benefits the week of May 2, 2011 with a letter dated April 28, 2011; nearly a month after being admitted into the ER, and after my medical tests were conducted. . . . This is the explanation as to why the benefits were reinstated on May 6, 2011 – I was notified that week that my benefits were reduced and took action to complete the meaningless web survey. I would never have agreed to conduct these tests had I known BCN reduced my coverage.

Commissioner's Review

Under Michigan law, health maintenance organizations are permitted to offer wellness programs which provide for reduced copayments, coinsurance, and/or deductibles if certain conditions are met. Section 3426(1) of the Insurance Code, MCL 500.3426(1), provides:

> Each insurer providing a group expense-incurred hospital, medical, or surgical certificate delivered, issued for delivery, or renewed in this state and each health maintenance organization may offer group wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program offered by the employer.

As a condition of joining or remaining in BCN's wellness program, a BCN member must meet requirements specified in the rider:

> HOW TO EARN THE HEALTHY LIVING ENHANCED BENEFITS IN THE FIRST YEAR OF ENROLLMENT
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> Upon enrollment each Health Living Eligible Member will receive Enhanced Benefits for a 90-day period. To continue receiving the Enhanced Benefits each Health Living Eligible Member must take the following steps:
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> 1. Within 90 days of enrollment each Healthy Living Eligible Member must complete a Health Risk Assessment (HRA) and a Healthy Living Enrollment Form which will assess the Member's medical condition and/or lifestyle behavior in relation to the following areas:
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>   - Blood pressure
>   - Smoking
>   - Cholesterol
>   - Blood sugar
>   - Weight
>   - Alcohol use
>
> 2. In order to earn the Enhanced Benefits, Healthy Living Eligible Members must achieve a score of 80 points or more on the Healthy Living Enrollment Form. Scores are based upon a combined assessment of the Member's current medical condition and/or lifestyle behavior and the member's commitment to comply with the conditions of programs and behaviors recommended by their primary care physician and BCN. The results of the Healthy Living Enrollment Form must be reviewed with and signed by the Member's primary care physician. The results must be submitted to BCN within the 90-day time period.
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> * * *
>
> HOW TO EARN THE HEALTHY LIVING ENHANCED BENEFITS IN SUBSEQUENT YEARS OF ENROLLMENT
>
> Healthy Living Eligible Members who have qualified to earn Enhanced Benefits in their preceding year may continue to earn Enhanced Benefits by following the

> steps outlined in "How to Earn the Healthy Living Enhanced Benefits in the First year of Enrollment", above. These steps will begin on the date of renewal of each year of enrollment.

The Petitioner does not dispute that he failed to submit the required health assessment form by the deadline. The Petitioner claims that this form is useless because his annual physical exam proved that he was healthy at the time the form was due. The Petitioner requests that the Commissioner invalidate BCN's health assessment form requirement for that reason.

The Commissioner declines to adopt the Petitioner's view of the health assessment requirement. The form is not merely a restatement of information found in a physical examination report. The form is also a tool to measure the commitment by the BCN member to continue to abide by practices that promote good health. Such a requirement is within the scope of initiatives permitted under section 3426 of the Insurance Code, the statute quoted above which regulates the wellness coverage offered by insurers and HMOs.

There is no dispute in the record that the health assessment form was not submitted on time. Because the form was not submitted timely, the Petitioner was not eligible for coverage at the enhanced benefit level during the time period in question.

V. ORDER

The Commissioner upholds Blue Care Network of Michigan's final adverse determination of July 28, 2011. BCN is not required to restore the Petitioner to the enhanced benefits plan for the period of April 1 through May 5, 2011.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner